RFI Response
for
Actuarial and Economic Modeling of West Virginia Health Insurance Exchange

Submitted to
State of West Virginia
Department of Administration
Purchasing Division
Attn: Shelly Murray
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Table of Content

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2. *Actuarial Services and Economic Modeling:*

2.1. Open Enrollment Strategies

Explain open enrollment strategies and impact such strategies could have on the insurance market, inside and outside of the exchange.

Having continuous enrollment periods on the exchange encourages healthy individuals not to buy insurance until they are ill; or only unhealthy people from buying insurance from the exchange, or people switching between different plan tiers based on their health services requirements, which will further contribute to adverse selection in the exchange market vis-à-vis market outside exchange.

Though, the PPACA has an individual mandate, which if implemented, will ensure that all residents – healthy or unhealthy – have health insurance. But irrespective of whether it is implemented or not, we suggest having a limited enrollment period for the exchange and imposing penalties on people buying insurance outside of enrollment periods. This will encourage residents to buy health insurance coverage irrespective of their health status. If they see themselves or their families at high or low health risk, they can choose a plan with appropriate actuarial value out of the five levels of coverage available. Limited open enrollment periods will make sure that the insurance market is not diverted outside of exchange. At the same time, people should be educated about the benefits of buying health insurance through the exchange during open enrollment periods i.e. no penalties, having greater access to health care services in the event of illness, eligibility to exchange subsidies and reduced personal financial risk of going without coverage.

Our Exchange Solution can be set up for enrollment within the open enrollment periods (initial and annual) and during special enrollment periods if qualifying conditions are met. Our solution provides a standardized Enrollment eApplication that can be seamlessly integrated with our Eligibility Determination module. For special enrollment periods, our

solution provides a way to file a change in circumstance, only against a valid set of qualifying conditions that then re-determines a family's eligibility to enroll.

Our Enrollment eApplication module also supports a broker, navigator or customer support executive filling application on consumer's behalf.

2.2. Risk Adjustment Methodologies

Analyze Risk Adjustment methodologies and recommend best approaches to comply with state and federal goals

A Consumer health survey method can be used where a health questionnaire can be developed for consumers to collect information on individual's age, illnesses, and other factors. Response to each question generates a numeric value or risk score based on a risk assessment algorithm. Thus, a weighted average value for population subscribing to each non-grandfathered plan can be determined and can be used to compare the relative risk of one non-grandfathered plan to the average actuarial value of all plans in state (not self-insured). This would require enforcement upon consumers to complete this questionnaire which will lead to an administrative burden and availability of data would depend on the willingness of people to respond. This approach can be used when the risk adjustment program is started, but should be replaced by a claim data based approach as claim data becomes available.

A Claim data based approach is where diagnosis and procedure data from inpatient and outpatient claims and pharmacy data from pharmacy claims can be used in addition to the demographic information like age, gender, income status, etc., to come up with a risk score of a plan's population. Since a diagnosis based risk assessment is more accurate. This can be achieved by having an all payer claims database and by applying risk assessment tools at the Exchange's end or by asking plans to report their risk profile and costs using standard set of risk factors and scoring mechanisms published by State. The state will also need to put in an audit mechanism in place, to prevent up coding by health plans and to make sure they are reporting correct risk profile and costs. In this approach, though claim data may not be immediately available for previously uninsured enrollees but the risk assessment would be more accurate.

Once the relative score the average actuarial value is determined for a plan, charges can be levied or payments be made either at the beginning of plan year or periodically.

2.3. Reinsurance Options

Assess reinsurance options

We recommend a fixed payment schedule method, where a payment amount is tied to a set of high risk medical conditions; it might be difficult to determine payment amounts for rare conditions. The payment amount for each condition will need to be reduced over the period of three years. A payment schedule can be based on expected cost. Once the payment amount for a carrier is determined based on payment schedule, there is another challenge of making sure that the payment amount does not exceed the contributions amount. Year-end reconciliation can be done to recover an additional amount from carriers if required. Payment amounts should be co-ordinated with a risk-adjustment program, so that a carrier is not paid twice for the same medical condition. This method would not add administrative burdens in addition to what is required for a risk adjustment program. Only the reconciliation program would require some administrative work if advance payments to carriers are made.

In the traditional reinsurance approach, where a reinsurance payment is based on the medical costs incurred over and above a deductible amount, this has little cost control incentives, since the payment is based on the cost incurred. Also, to support this program, plans would be required to file proofs of their cost/utilization.

2.4. Impact of Reforms on Premiums

Analyze various reforms and the impact such reforms, potential and actual, will likely have on premiums in different markets

The impact of reforms on premiums of individual and small group plans will depend on many factors. These include characteristics of the health insurance markets prior to reform, whether plans are grandfathered or are newly created, the health status and claims experience of the covered group or individual, individual coverage decisions, policy decisions that will be made at state level, and success of cost containment efforts.

The following are the impacts of reforms we foresee –

- Reducing lifetime limits may lead to a slight increase in premium by around 1 percent, with small group impact lesser than individual market impact.
- Removal of preexisting criteria may lead to increase in premium by around 1 percent in individual market.
- Extending coverage of dependents till they are 26 on their parents' group plan is expected to increase group plan premiums from .5 to 1.2 percent.

- Premiums in the new individual market should be considerably less than those of grandfathered plans because of federal subsidies, individual mandate bringing in a lot of healthier enrollees and lower administrative costs expected to be associated with exchange based insurance coverage.
- Minimum benefits standard may increase premiums relative to the situation without them.
- Removal of gender based rating will benefit young women at the expense of young men, and benefit older men at the expense of older women.
- There would be downward pressure on premiums due to
    - Introduction of benefit tiers and easy comparison tools through exchange which should make shopping on price more feasible for consumers
    - Detailed reporting of administrative cost of plans to differentiate between efficient and non-efficient plans
    - Reporting on consumer grievances, to identify whether plans have lower costs due to inferior services or due to efficient practices.
    - Ability of exchange to exclude carriers offering higher premiums
    - Premium monitoring at both state and federal level
    - Risk adjustment within exchange and non-exchange plans and in group and non-group markets, allowing plans to set prices based on service provision and efficiency as opposed to risk of enrollees.

2.5. Measures of Success

Determine what measures should be used to define success

The following should be used as measures of success for the exchange:

- It should maximize choice for all participants, should be easily accessible, ensure fair competition and prevent dominance by a few carriers.
- Governance of exchange should be publically accountable
- It should minimize administrative costs and adverse selection
- It should give a broader access to service providers and should provide for continuity of care.
- Should encourage employees, employers, individuals to maintain good health and encourage more efficient use of health care services

2.6. Actuarial Valuation in Benefit Levels

Explain the options regarding the methodologies for standardization and operationalizing the actuarial valuation of different benefit levels in the Exchange in accordance with the state and federal laws

Federal requirements mandate standardization of plans in different benefit levels in the Exchange. Plans should have actuarial values of 60% (Bronze), 70% (Silver), 80% (Gold) or 90% (Platinum). There is another level that is catastrophic for young people. There are many ways in which these actuarial values can be achieved. For instance, one platinum plan might have a $200 deductible and 80% coinsurance, while another platinum plan might have a $0 deductible and 90% coinsurance, with both plans having the required platinum actuarial value of 90%.

If States postpone plan standardization for one or more years, it would give carriers time to adapt to the new regulations and respond to consumer preferences in the market. In later years, the HBE might choose to allow only standardized plans. Medical inflation on fixed dollar cost sharing features (e.g. deductibles and co-pays) will cause the actuarial value of benefit plans to increase over time. Actuarial value can also change from changes in the mix of members by age, health status, geographic area, or other variables that affect average claim costs per member. When a State tests plans for compliance with the target actuarial values, they should normalize for any such changes or differences in the mix of enrollees among the benefit levels.

2.7. Medical Loss Ratio

Recommend methodologies to standardize and enforce the new medical loss ratio requirement in federal law

The NAIC has submitted to HHS the standard list of activities and reporting standard for plans to report their costs for calculation of MLR for different types of plans. If MLR is less than required (80% or 85%), then rebate should be calculated using standard metrics and be distributed in the form of dividends or credit on premium payments. The State Insurance Commissioner should audit plans annually and if they fail to meet the reporting requirements, penalties should be imposed. For small insurers, "credibility adjustment" factor should be applied to MLR, because their claims fluctuate randomly from year to year and the ratio may not indicate the actual premium amount spent on medical and health care quality costs over a period of one year.

2.8. Adverse Selection

Assess adverse selection impacts of various legislative and policy decisions

The following PPACA's initiatives will most likely reduce adverse selection:

- Requiring many of the new market rules to apply both inside and outside the exchange
- Requiring all plans (except grandfathered and self-insured plans) to cover a set of "essential benefits"
- Requiring insurers to treat all enrollees, inside and outside the exchange, as members of a single risk pool
- Establishing three risk adjustment programs to reallocate risk among insurance companies critically
- Requiring those who are eligible for premium and cost-sharing subsidies to enroll through the exchanges
- Individual mandate that dilutes the risk to insurers of covering sick patients and thereby restrains the price of premiums

Whereas, the following may increase adverse selection:

- Age bands in the individual market narrowed to a maximum of three to one, which is lower than currently used in the industry (e.g., five or six to one) which may increase premium for young and may further discourage young people from buying insurance.

Taken together, the individual mandate, penalty, and subsidies should reduce adverse selection in the individual and small-group markets, with adverse selection shrinking further as greater coverage is achieved.

2.9. Merging Small and Non-Group Market

Model the impact of merging small and non-group markets, including the impact on premiums for individual consumers and for small employers and their workers

For the exchange to be successful in the long term, the state should keep individual and small-group markets separate. Keeping the two separate is important for both the pooling of risk and for the administration of health insurance premium subsidies available to low-income individuals who purchase coverage through the exchange.

Though combining the two pools will make the entire exchange risk pool larger, theoretically reducing costs and possibility of adverse selection by individuals. But the individual risk pool is already being expanded, through Individual mandate and employer responsibility to provide affordable coverage to their employees. Additionally, there is a requirement in PPACA that carriers must pool all of their individual coverage risks together, regardless of whether the coverage was purchased through the exchange or not

(excluding grandfathered plans), and there is a similar requirement for carriers regarding all small-group business.
Combining the two may lead to an increase in small group premiums and a decrease in individual premiums from current levels, which can make things difficult for small employers. It would likely cause adverse selection to the small-group pool, which would ultimately be much more costly to the exchange's participating consumers and health plans, and the insurance marketplace in general. Not mixing the pools will promote greater long-term health insurance market and exchange stability.

For health plans, combining the two pools will lead to significant infrastructure changes that would be both costly and time-consuming to implement and would certainly impact the price of premiums. Furthermore, it might reduce competition because some carriers may not find if profitable to remain in the individual and/or small-group markets.

2.10. INCREASING SMALL GROUP MARKET BY 2016

Model the impact on premiums and access to coverage of increasing the definition of small group market to include employers with up to 100 employees before 2016 and starting in 2016

When the small group market is expanded to include employers up to 100 employers, premiums for small group plans should come down because of a bigger risk pool. Some of the groups from 50-100 employees that are self-insured or uninsured will enter the market and will be able to access affordable coverage through the exchange. Some of the fully insured employers that have healthier employees may elect to self-fund to avoid federal requirements of community rating and minimum loss ratios. This can result in adverse selection that could increase the costs for small employers in the exchange. But this can be controlled by putting state regulations in place to avoid such a scenario. Such employers which are driving high risk enrollees to exchange because their employees cannot get an employer-sponsored affordable coverage are liable to pay financial penalties, if their employees qualify for federally subsidized exchange coverage.

Combining the two markets should also lead to lower administrative costs per member. Also, allowing uninsured groups between 50-100 employees will give them access to more insurance options.

2.11. INSURERS POOLING PRACTICES TO MAXIMIZE THE BENEFIT OF SHARED RISK

Make recommendations to ensure that insurer's pooling practices maximize the benefits of shared risk, including positive impacts for consumers on rates

We recommend that individual risk pools inside and outside of the exchange be merged and small group pools inside and outside of exchange be merged excluding the grandfathered plans. But the state should refrain from merging Individual and Small group pools, because merging these two will likely result in higher premium rates for small group members and may result in some of them dropping the coverage. Keeping them separate will give time to states to focus on other market changes and will make it easy for carriers too. It would also allow subsidies between individual and small group market which operate very differently from each other.

2.12. LIKELY BEHAVIOR IN NON-GROUP, SMALL GROUP AND LARGE GROUP MARKET

Model likely behavior in non-group, small group and large group market in response to specified market changes and policy decisions

Individual Market: A large chunk of previously uninsured population and insured population in the individual market is expected to go to the exchange to purchase plans due to low premiums and federal subsidies. Most of the unhealthy, uninsured population will move to exchanges as they will recieve guaranteed coverage and may be eligible for subsidies. Since, 3:1 age ratio favors an older population; the older population will be more inclined towards obtaining coverage than the younger population, a number of younger people enrolling themselves will depend on how effectively the individual mandate is enforced. Most unhealthy people will subscribe to platinum plans, and if they qualify for a federal subsidy, then most healthy people may also want to go for platinum plans.

Small Group market: Small group market has a lesser incentive to participate in exchange as compared to individuals since tax credits are available within or outside the exchange. The premium rate changes also may not encourage small employers to enter the market. Unless exchanges provide administrative benefit to employers like helping employees enroll, small group enrollment may be limited.

Large group market: Reforms may drive up costs of large employers as they will have to provide coverage to their employees. But they would rather insure their employees than pay extra tax payments.

2.13. IMPACT OF SELF-INSURED MARKET ON EXCHANGE

Model the impact of self-insured market on the Exchange and recommend various approaches to mitigate adverse impact

The Self-insured market may not have an adverse impact on the Exchange because of the following reasons:

- Research studies show that the risk level of self-insured plans is comparable to fully-insured plans (Source: CRS Report to Congress, Congressional Research Service, Library of Congress, March 29, 2006)
- PPACA has a risk adjustment process in place for all plans within and outside of exchange
- PPACA contains reforms-like subsidized coverage, and a premium review process etc. that will open access and reduce costs for small groups

As per a study by SIIA (Self-Insurance Institute of America), there are no major differences historically between the health risk profiles of insured and self-insured plans and that both funding methods cover a cross-section of all health risks. And numerous provisions of the PPACA incentivize small employers to remain in the exchange while also providing safeguards against changes in rates for employers who maintain exchange-based coverage. So there should be no reason to believe that there will be any adverse selection within any of the State exchanges.

2.14. Financial Impact of Insurance Coverage of Abortions

Model the cost of state-mandated benefits to assess the financial impact of non-public and public funding insurance coverage for induced terminations (abortions)

Under the PPACA, for health plans that cover abortion, the abortion coverage must be paid for separately by the enrollee with his or her own funds. This private premium must also be kept in a separate account that must be audited by the states. Given the added costs of administering these separate funds, it is likely that insurers will have little interest in offering such plans. This is particularly true because of the pressure PPACA's minimum loss ratio requirements put insurers under to limit their administrative costs. States may also have to put additional administrative structures to monitor plan premium structure, funding of abortions and auditing health plans abortion accounts. Additional research is required as to a plan's inclination towards providing abortion coverage.

2.15. Impact of Migration between Public Health, Public Sector and Commercial Health Insurance Plans

Discuss the impact of migration between public health, public sector and commercial health insurance plans and programs based on price, tax benefits, benefit and plan designs and the effects on state insurance and tax laws

We will have to work with the state in a collaborative manner to access the impact of migration between public health, public sector and commercial health insurance plans and programs based on price, tax benefits, benefit and plan designs and the effects on state insurance and tax laws.

2.16. MEASURING COST OF STATE-MANDATED BENEFITS

Develop methodologies to measure the cost of state-mandated benefits, including estimations of the net costs of mandates (taking into account the effect of savings resulting from coverage and proper delivery of mandated services), marginal costs (taking into account coverage for mandated benefits that insurance plans already provide), and estimations of out-of-pocket costs to consumers if coverage for mandated benefits is not provided

We recommend coming up with a per member/per month cost for each mandate. The member can be assumed to be an average person, age less than 65 years old, living in West Virginia in 2011 and having comprehensive major medical insurance in an employer-based or individual insurance plan. The costs can be based on allowed charges (i.e., billed charges for covered services, reduced by average provider discounts, but before application of patient costs sharing such as deductibles, coinsurance, or co-pays).

2.17. STANDARDIZED BENEFIT PLANS

Analyze the potential benefits or detriments of standardized benefit plans

Potential benefits:

- Easy comparison between plans for consumers, hence lesser cost on support staff of explaining plan features
- Exchange administration for maintaining and certifying plans will become simpler

Potential detriments:

- Exchange enrollment may be less if consumers find more attractive plans outside exchange
- Scope of differentiation for carriers is reduced
- Benefit innovations like customer directed health plans may not be possible

Detriments are usually disadvantages for high income population and carriers that were addressing the customized needs of this population. These were only inducing a lot of

unnecessary health care costs. To reduce overall health care costs, we strongly advocate standardization of benefit plans.

2.18. ANNUAL COST OF EXCHANGE OPERATION STARTING 2015

What will be estimated annual cost of exchange operations be, starting in 2015

The annual cost will depend on a number of factors. For example, the MA Connector and Utah Small Business Exchange operate on very different models and have very different cost structure.

2.19. FUNDING FOR EXCHANGE STARTING 2015

Develop and analyze various models for maintaining necessary funding for the exchange starting in 2015, including through assessments on insurers

We recommend following approaches to ensure the exchange will be financially self-sustaining:

- Charging Health Plans an administration and enrollment fee on a per member basis. This fee can be levied as a % of premium or a fixed fee per member.
- Charging Health Insurance companies for the certification and recertification of their plans to be provided on the exchange
- Brokers who want to do business on the exchange can also be charged a small one time administrative fee and recurring renewal fee for leveraging the exchange.

Furthermore, we recommend that the Exchange work very hard to minimize fixed costs. Third-party fees (TPA, call centers, technology provider, hosting etc.) should be linked to volume. This will allow expenses and revenue to mirror each other and avoid major shortfall because of differences between forecasted numbers and actual numbers.

2.20. IMPACT OF EXCHANGE ON MEDICAID, MEDICARE AND OTHER GOVERNMENT PROGRAMS

Evaluate and discuss the impact of the Exchange on Medicaid, Medicare and other government programs and how to accommodate those impacts

Medicaid costs are likely to go slightly up from 2014 up to 2019, because of expanded coverage up to 133% of federal poverty level. From 2014 to 2016, the federal government will take care of 100% this extra spending and will gradually decline this financial support

through 2020 and thereafter. There could be slight increase in the number of enrollees under existing criteria because of the individual mandate and outreach programs but these can be countered by Medicaid eligible population above 133% going to exchanges and get federally subsidies.

The dollars that finance Medicaid expansion and tax credits ultimately come from providers (who face lower Medicare payments) and higher income individuals (who face increased taxes on payroll and unearned income). These providers and individuals are located in the same states that benefit from an influx of federal dollars to cover the previously uninsured. Thus, while the PPACA generates huge gains to state governments as well as the economic growth that results from higher health care spending, the losses to providers and the federal taxes paid by various firms and individuals will have somewhat offsetting effects.

We do not see much impact on Medicare enrollments due to exchanges.

2.21. FINANCIAL BURDEN OF OBTAINING HEALTH COVERAGE

Evaluate and discuss the potential solutions for the financial burden of obtaining health coverage – specifically, how federal subsidies and cost sharing will impact Medicaid, CHIP and other government program eligible and enrollees

CHIP funding is guaranteed only through 2015. Once states use up their allocations for CHIP, children can move to exchange plans where they can get federal subsidies. Overall, state financial burden for CHIP should fall considerably. Similarly, Medicaid population above 133% of FPL will move to exchange to get subsidized insurance which will reduce state's financial burden.

Also, federal subsidies direct consumer spending from healthcare to other goods and services, which may have a positive impact on state economies and tax revenue.

3. APPROACH:

Because of the tight deadlines to implement provisions of PPACA, we recommend that State of WV come up with a list of exchange features based on the research conducted, and then choose the vendor who already has an Exchange solution rather than developing a solution from scratch. Our exchange solution has all the components required to implement Exchanges as per PPACA provisions and can be customized to meet special reform requirements of the State of West Virginia.